Use of Unlicensed Assistive Personnel

A National Council of Nursing Position Paper

Approved January 1998

Issue:

Decreasing risk and ensuring continued quality of care as more Unlicensed Assistive Personnel are used in Indian Health Service patient care settings.

Background:

Unlicensed Assistive Personnel (UAP) are a reality of health care. They have been used in a wide variety of settings and under a variety of names and titles for years. However, recent changes in the health care environment have seen controversy over the appropriateness of their use and the impact on patient care. Although recent focus has been on the use of the UAP in the nursing setting, it is recognized that they are used throughout Indian Health Service (IHS), as dental techs, physical therapy techs, pharmacy techs, lab techs, community health representatives, etc. Their most comprehensive and expanded use has been as Community Health Aids in Alaska, where they function independently in extremely rural and remote locations. "Unlicensed Assistive Personnel" is defined as, "a health care worker who is not licensed to perform nursing, medical, or other health care tasks."

The Indian Health Service (IHS) National Council of Nursing (NCON) recognizes that there are basic issues in the use of UAP that transcend health provider categories and that ultimately the issue is the quality of care the patient/client receives.

Discussion:

Concerns regarding the use of UAP evolve around:

1. Professional practice acts;
2. Training and education;
3. Delegation;
4. Staffing mix;
5. Supervision;
6. Risk management;
7. Quality assurance/performance improvement; and
8. Customer satisfaction.

These issues apply, regardless of the type of UAP or their clinical setting; whether they assist nurses, physicians or other health care professionals.

Professional Practice Acts:

It is generally believed that federal supremacy reigns, even in issues related to professional practice acts. That is, the needs of the IHS dictate what we ask our professional and non-professional staff to do, even if that falls outside of their scope of practice. Federal attorneys have said that as long as duties are in the official job description, the employee is covered by the Federal Tort Claims Act, and immune from individual suit. Some states

indicate that they do not feel they have jurisdiction over federal employees, even though licensed by the state. Other states indicate they expect licensed professionals to practice within their practice acts, regardless of working for the federal government. NCON has repeatedly requested a definitive legal decision regarding this issue.

It appears that "federal supremacy" will cover both the UAP and the supervising licensed health care professional against lawsuit. It is less clear whether federal supremacy will protect the license of the health care professional practicing outside the bounds of his/her practice act.

Training and Education:

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requires that all employees be adequately trained to perform the duties they are assigned and that the employee's competency be reassessed at regular intervals. JCAHO leaves it to individual organizations to define how "adequately trained" and "competent" are measured. Much of the discussion regarding UAP has centered around these issues, including what needs to be taught, who teaches it, and how do we assure that what is taught is put into practice. The IHS has a responsibility to assure that all its employees are adequately trained and qualified to perform the duties of their position.

Delegation:

In the evolution of health care, lines of demarcation between health care professions, as well as between health care professionals and non-professionals, is blurring. General practitioners are performing more specialized treatments; nurses are performing more tasks originally thought of as "medical practice"; UAP are performing tasks once thought the exclusive realm of licensed professionals. Each health care profession is responsible for determining which tasks within it's scope of practice are suitable for delegation to another health care professional or worker. The delegation decision making process should include the "Five Rights of Delegation":

1. Right Task
2. Right Circumstance
3. Right Person
4. Right Direction/Communication
5. Right Supervision/Evaluation.

Staffing Mix:

The optimum mix of professionals and unlicensed staff required for any given setting has yet to be determined. The mix will vary depending on the professional practice (e.g., nursing versus dental), the practice setting (e.g., hospital inpatient versus free standing ambulatory care); as well as the number and acuity of patients seen. Other issues include adequate supervision of the UAP by professional staff; and the level of experience and training of both the UAP and the professional staff.

Supervision:

Unlicensed Assistive Personnel should be supervised by licensed health care professionals. This supervision includes the appropriate delegation of tasks (see "Delegation" above); assuring that the task has been performed; evaluating the outcome; and providing feedback. The supervising professional needs to be qualified to delegate tasks; determine the quality of care provided; recognize adverse outcomes; and initiate interventions, both clinical and personnel, in the event of adverse outcomes, etc. Unlicensed Assistive Personnel should be supervised by a licensed health care professional in the same field of practice.

Risk Management:

The IHS takes a proactive approach to risk management. Early identification of potential risks and prevention of incidents which put employees and/or clients at risk is a major focus. Annual costs from tort claims continue to rise and every claim or complaint lowers the esteem of IHS in the public's eyes and reflects negatively on the quality of care we provide. Management decisions regarding staffing levels and mix need to take potential risks into consideration and mobilize efforts to reduce them. Professional staff should not routinely be replaced by UAP unless the impact on patient/client care is clearly understood and assessed.

Quality Assurance/Performance Improvement:

Whenever the process or practice of providing services and care changes, it is good management practice to assess the impact of such changes on patient care. The IHS continually strives to improve the quality of patient care and the pros and cons of any changes must be carefully evaluated to eliminate negative impacts. Of special consideration and concern is that clients with similar complaints or problems receive the same level of care, regardless of the type or level of care provider.

Customer Satisfaction:

The Indian Health Design Team emphasized the need for the IHS to be more responsive to the needs and desires of our clientele. Customer satisfaction regarding any significant changes in staffing or staffing mix should be considered and evaluated. Of utmost importance is that our clients know, and understand, who is providing their care.

Recommendations:

The NCON recommends that the following be considered when implementing or continuing the use of UAP in any Indian Health setting.

Practice Factors:

1. Determine the patient's needs regarding the level and complexity of care and interventions required. The more complex the need, the higher the level of care provider needed.
2. Determine the patient's risk for adverse outcomes. This may be related to the age, socio-economic status, support network, diagnosis, presence of complications, level of

services available, etc. The higher the risk, the higher the level of care provider needed.

3. Determine the patient's need for education. Certain basic education, e.g., how to raise and lower a hospital bed, may be within the scope of work for UAP. The more complex the education needed, the higher the level of care provider required.
4. Determine that skills and functions required of UAP may be delegated under the related professional practice act.
5. Specific duties that may or may not be performed by UAP are determined by the relevant professional category, based upon legal limitations, education, training, environment, staffing number and mix, supervision, and patient acuity.
6. Where duties overlap one or more professional categories, as is the case for Community Health Aids in Alaska, representatives of all relative professional categories will be involved in defining duties and limitations. One specific professional category should be designated formal supervisory and quality assurance responsibilities, but should liberally seek assistance from other related professional categories in evaluating the safety, quality and effectiveness of an individual or program.

Training and Education Factors:

1. Licensed health care professionals who supervise UAP must have the training, experience, and competency to delegate tasks. The ability to delegate is not automatically conferred with a professional license.
2. The level of preparation and education required to perform desired delegated tasks must be determined.
3. Unlicensed Assistive Personnel must receive didactic and psychomotor training specific to the tasks to be delegated. Behavioral outcomes for training should be established by the responsible professional category, i.e., dentists establish outcomes for dental assistants, physical therapists establish outcomes for physical therapy techs, etc.
4. Unlicensed Assistive Personnel must demonstrate initial and on-going competency for delegated tasks, to the satisfaction of the supervising licensed health care professional.
5. Training and competency assessment for individuals must be clearly documented and kept on file.
6. Where duties overlap one or more professional categories, as is the case for Community Health Aids in Alaska, representatives of all relative professional categories will be involved in defining required training. The designated supervisory profession may evaluate the effectiveness of training and competency, with collaboration with other related professional categories.

Management Factors:

1. Professional staff should not routinely be replaced by UAP, without full understanding of the impact on the quality of patient/client care and services provided.
2. Written position descriptions for UAP must clearly delineate which patient care activities can be performed and under what circumstances.

3. The responsible IHS professional category will develop and/or approve position descriptions for UAP.
4. The responsible IHS professional category will develop a list of technical skills appropriate for performance by the related UAP, including skills which may never be performed by UAP, as appropriate. When specific tasks to be delegated cross over professional category lines, e.g., medication administration, collaboration between the related professional categories must occur to assure the same level and quality of care is provided regardless of where and by whom the service is provided.
5. Written performance standards must assess the accuracy, quality and quantity of tasks assigned, as well as issues relating to reporting and documentation of problems or adverse reactions, findings, or changes in patient condition.
6. Adequate, qualified licensed professionals must be available to supervise and coordinate patient care activities delegated to UAP. In most cases, supervision should be on site. In the unique situation of Community Health Aids in Alaska, supervision should be available via radio or land lines, with regular review of patient interventions and outcomes.
7. Patients must always be informed and aware of the level of staff providing care, both through identification badges and personal introduction.

Monitoring/Performance Improvement Factors:

1. Use of UAP, especially when first implemented, must be monitored to assure continued quality of care.
2. Adverse events must be reviewed, trended and assessed to prevent recurrence.
3. Repeated negative occurrences by an individual must be evaluated to determine if a knowledge or performance deficit is involved.
4. Plans for corrective action must be developed, implemented and evaluated.
5. All performance improvement activities must be clearly documented.
6. All professional categories should actively support on-going research into the impact of UAP on IHS and quality of care.

Implementation of these recommendations by the Indian Health Service will facilitate use of Unlicensed Assistive Personnel across professional categories, and assure quality of care, regardless of the practice setting.